

At the bifurcation of the trachea a great quantity of dirty milk-like mucus was met with. As to the remaining organs, the thymus was less developed, both the lungs of normal appearance, with the exception of the top, which exhibited several more compact, somewhat liver-like, dark-red spots. The heart was deep-red, and as well as the pericardium, was engorged with venous blood. In the pericardium there was about a spoonful of yellow serum. The valve of the foramen ovale was not yet quite closed. The main vascular trunks were of healthy structure. We learn from these post-mortem appearances that in this case the pulmonary circulation had not yet been fully developed, in consequence of which the brain became gorged with blood, and at last apoplectic.

There are two diseases which might have been confounded with that just described, asthma stridulum and croup. These differ, however, in many points; the former by its more tardy appearance, the non-permanency of the dyspnoea, the tetanic spasm, and complete interruption of the respiratory process at the close of life; the latter by the normal deglutition, and in common with the former, by its more tardy appearance.—*Ibid.*, from Caspar's *Wochenschrift*.

34. *Case of Ichuria Neonatorum.* By ALON BEDNAR.—A child, who died on the 13th day after birth, during the last five days while he was under the care of the reporter, passed no urine. It does not appear whether or not he had passed any on the previous days. The dissection showed the following very interesting state of the parts. The caput gallinaginis, instead of passing, as in the normal structure, into a prominence, ending in two branches which again divide into a great number of little folds, was here branched at its anterior extremity, into two mucous valves, running along the walls of the urethra, from behind downwards and forwards, towards the middle space where they united together. These two crescentic valves, with their concavity looking towards the bladder, included between their combined terminations, a very narrow fissure running necessarily from behind forwards. From the structure it is evident that whenever the bladder contracted on the urine, the cavity of the valves became filled with it, and the fissure between them being completed by their distension, not a drop could issue beyond. It was easy to pass a thick probe from the anterior part of the urethra into the bladder, but when the probe was passed from the bladder, it was impossible to reach the urethra without the assistance of the eye, the probe being otherwise continually thrown back by the valves. As to the surrounding parts, the rest of the urethra and genitals were quite healthy; the urinary bladder was hypertrophied, its usual thickness being trebled, the thickening being principally in the muscular coat. On the inner surface of the bladder there was seen an incipient tubercular tissue, moreover some little pervious dilatations, and a greater sac with a sphincter-like opening at the termination of the left ureter. The remaining portion of the ureter was dilated and thickened, the renal substance was atrophied. As it cannot be assumed that the high degree of hypertrophy and dilatation of the urinary organs had been developed during the short continuance of life, it is very probable that as soon as the secretion of urine commences, there is a necessity for its evacuation by the urethra. And hence, also, it is to be inferred that an empty urinary bladder is not to be regarded in forensic medicine as one of the evidences of an infant having lived after birth.—*Ibid.*, from Zeitschr. d. Gesellph. d. Ärzte zu Wien, Feb. 1847.

#### SURGICAL PATHOLOGY AND THERAPEUTICS, AND OPERATIVE SURGERY.

35. *Influence of the Laws of Gravity on Circulation and Local Inflammation.*—Prof. GERDY read to the French Acad. of Medicine, May 25th, an interesting paper of a practical nature on this subject. The author remarked that the influence of the laws of gravity on the circulation, was often evident in the production or increase of cephalgia, of œdema of the extremities; that it was sometimes an obstacle to the cure of hydrocele after operation, as also to absorption of hydropsis of the knee or ankle; that it occasioned the displacement and extension

of ecchymosis, and favoured the development of uterine hemorrhage, of hemorrhoids, and of varicose veins; that diffused or circumscribed phlegmonous inflammation, could frequently be ascribed to no other cause, and consequently, that those parts of the body which their dependent situation most exposes to these various affections should, on the imminence of any one of them, be placed in an elevated, or, at the least, in a horizontal attitude. This was a precept of general practice, applicable to a vast number of different disorders, and which should, therefore, never be lost sight of.

M. Nacquart expressed a regret that Professor Gerdy had not established a comparison between the influence of position and that of compression on inflamed parts. The method of compression with strips of adhesive plaster, had been by error attributed to the British surgical school, but had, in reality, been introduced into practice by French surgeons more than thirty years ago. M. Nacquart had seen it applied in Paris, and he thought it might with advantage be substituted to elevation of the limbs, to which M. Gerdy had granted so much influence in the treatment of phlegmonous affections.

M. Malgaigne agreed with M. Gerdy in praising the results obtained in inflammations, by elevation of the part. The method was in its nature so simple, that it might be supposed to have been suggested in the most elementary works on surgery; such was not, however, the case. The manner in which a violent local inflammation might be reduced in a few hours, under the influence of a mere change of position, was in itself something marvellous. It was a fact of every day observation, that when a whitlow caused excessive pain, the sufferings of the patient might, in a few minutes, be relieved by elevation of the hand. M. Malgaigne then related several cases illustrative of the same fact, and made some further remarks on another point connected with the subject—viz., the possibility of arresting hemorrhage in one organ by elevation of another part—for instance, epistaxis was often stopped by raising the arms. Here, again, most probably the influence of the laws of gravity on the circulation of blood, was the cause of the beneficial effect of this practice; and so convinced was M. Malgaigne of their efficacy, that when, after the operation for hydrocele, the inflammation of the tunica vaginalis did not occur within the usual time, he prescribed merely that the scrotum be abandoned for a few hours to its weight—a plan which was invariably followed by the desired congestion of the parts.

M. Gerdy could not think that compression, with strips of adhesive plaster, might be substituted for position. In fact, this compression often did more harm than good; whereas elevation of the limb constituted an incessant withdrawal of blood from the part, without loss of the circulating fluid. M. Gerdy concluded his remarks by stating that the advantages of his method were particularly distinct in cases of atonic ulcer of the leg.—*Medical Times*, June 5, 1847.

[The late Prof. Physick, of the University of Pennsylvania, was accustomed, in his lectures, to lay great stress upon the importance of position in the treatment of local inflammations, and many years ago inculcated the very views now put forth as new by Prof. Gerdy and M. Malgaigne.]

**36. Wound of the Brain—Recovery.**—The *Journal de Médecine, de Bordeaux*, contains the following interesting case of a wound of the anterior lobe of the brain, in a child, not followed by any mischief. A child, aged twelve, made a false step, holding at the time an open knife in his hand. In the fall, the knife being directed towards the head, rapidly penetrated through the left orbit. The lad did not raise any cry, but ran into the infirmary of the establishment in which he lived, the knife still sticking in the head. When M. GINTRAC was called to him, he found him laid upon his bed without consciousness, the skin cold, and the face pale, the pulse imperceptible. The knife had passed between the globe of the eye and the upper eyelid, about midway between the orbital angles, and had perforated the orbital portion of the frontal bone, in which it was tightly fixed. Its direction was oblique—viz., from below upwards, and from before backwards, forming with the facial line an angle of about  $45^{\circ}$ . The back of the blade was next the globe of the eye, and pressed it downwards and backwards, while the cutting edge raised the upper lid. M. Gintrac sought at once to remove the knife; his first attempts were fruitless, but by persevering for five minutes, and with the

help of another, it was extracted. The entire length of the blade was three inches and one-fifth, its breadth two-fifths of an inch; it had penetrated, measuring from the margin of the eyelids, two inches. Whilst the proceeding was going on, the lad remained quite insensible. Compresses, with cold water, were ordered to the eye and forehead, and sinapisms to the feet. Between four and five hours afterwards, the boy had recovered his senses, spoke freely, suffered no headache, and complained only of a smarting in the interior of the orbit; the pulse began to rise, and there was some swelling of the upper eyelid, but pressure on it caused no pain. He passed a good night, sleeping calmly. The next morning the pulse was 60, and regular; intellect clear; answers naturally; no headache; some heat about the orbit; the eyelids not more swollen.

During the following days no new phenomenon presented itself; the tumefaction of the eyelids gradually decreased, and after the eighth day entirely disappeared, leaving the eye perfectly sound. All that was to be seen was a slight scar on the margin of the tarsal cartilage of the lower eyelid, made during the rapid passage of the knife past it. The patient was kept in bed fifteen days, during which his diet was very low; after this he resumed his studies and his ordinary employments.

To determine the question which necessarily arises in this case, as to whether the knife entered the brain, M. Gintrac had recourse to experiment: knowing the depth which the knife had penetrated in the above case, and the direction it took, he carefully drove, by a hammer, the same knife through the corresponding place in the orbit of a dead child, aged eleven years; then, having opened the head, he assured himself that the instrument had traversed the vault of the cranium, the membranes of the brain, and had penetrated into the anterior cerebral lobe nine-thirteenths of an inch. M. Gintrac would reject the notion as impossible, that the dura mater, with the brain, had, in the case related, only been pushed aside, on account of the intimate adhesion of the dura mater to the calvarium, its want of extensibility, the depth to which the knife had penetrated into the cranium, and the great resistance to its extraction.

The freedom from any after-accident from an injury of this nature is certainly remarkable, but by no means unparalleled; for, as is mentioned in the remarks on the above case, Mr. Selwin published in the *Lancet*, in 1838, the account of a case in which the blade of a knife entered the cranium, in a child four years old, through the upper part of the orbit, to the depth of about three inches and a half, wounding in its course, the optic nerve, and the levator of the upper lid. Its removal was long and troublesome, attended by some hemorrhage, and the wound giving vent to some fragments of brain. The child recovered, retaining its senses, but losing the vision of the eye which was wounded.

To this case may be added another, reported by M. Fournet, of an individual who, being desirous of destroying himself, took with his left hand a chisel, such as is used by cabinet-makers for making mortices in chairs, and having adapted it with its sharp edge to the centre of his cranium, armed his right hand with a wooden mallet, with which he drove the chisel into his skull up to the handle, this alone preventing its further penetration. In order to avoid too much movement in removing the instrument, M. Fournet made use of the proceeding adopted by Ambrose Paré to remove a portion of a blade from the cranium of the Duke of Guise. The patient was seated in a chair sufficiently low, the head being immovably fixed. M. Fournet got upon a table, and after having very tightly fixed the handle of the chisel in a vice, laid hold of the vice with his two hands, and exercised upon it a vertical, uniform, and continued traction. The instrument was thus removed, and after awhile the patient got well. In order to make himself acquainted with what part of the brain had been entered, M. Fournet drove into the cranium of a dead subject, at exactly the same point, in the same direction, and to the same depth, the very instrument which he had withdrawn from his patient. On opening the head, he found that it had traversed the inter-parietal (sagittal) suture, and the superior longitudinal sinus—had grazed by one side of the falk cerebri, between the two cerebral lobes, and had reached between the tentorium cerebelli, the posterior part of the corpus callosum, as far as the quadrigeminal tubercles, but without having at all injured them.

37. *Extensive Lacerated Wound of the Rectum and Bladder, produced by the Leg of a Chair.*—Mr. PRESCOTT HEWETT presented to the Pathological Society of London, Feb. 1, 1847, a specimen of this accident. The patient, a man, aged 43, was admitted into St. George's Hospital, under Mr. Keate, in a state of collapse, and complaining of severe pain about the vesical region, and over the lower part of the abdomen. He stated, that a short time previously, he had slipped off a table upon which he was standing, and that in his fall he had knocked over a chair, one of the legs of which having struck him on the side of the anus, had glanced off, and passed up the rectum. On examining the anal region, nothing was observed, with the exception of a slight laceration at the left margin of the anus, which did not penetrate more than a few lines in depth. A catheter was passed into the bladder, and a quantity of bloody urine drawn off. The pain soon spread over the whole of the abdomen, the collapse continued, and the patient sank, with symptoms of low peritonitis, in about twenty-one hours after his admission to the hospital. At the *post-mortem* examination no appearances of injury existed about the perineum; but there was some ecchymosis in the neighbourhood of the slight wound at the margin of the anus. At about two inches and a half from this opening, there was a large lacerated wound in the front part of the rectum, through which two fingers were easily passed into the bladder, at its fundus, and on laying open this organ another extensive laceration was found at the right side of its apex, leading into the cavity of the peritoneum. The leg of the chair having slipped up the rectum, had thus transfixed this organ and the bladder from its fundus to its apex. The peritoneum contained a large quantity of bloody fluid, mixed with recently-effused lymph.

The preparation is in the museum of St. George's Hospital.—*Lond. Med. Gaz.*, Feb. 1847.

38. *Tetanus following a lacerated Wound of the Cornea.*—The following example of this was communicated to the Royal Medical and Chirurgical Society (May 11, 1847), by GEORGE POLLARD, Esq.

J. S., aged 33, was admitted into St. George's Hospital, under Mr. Keate, on the 10th of January, 1847. He had that morning received a cut from a gig whip on the left eye, which lacerated the cornea, dividing it through its entire thickness, and extending obliquely across from one margin nearly to the other. The aqueous humour had escaped, but there was no prolapsus iridis, and but little pain or chemosis. Goulard's lotion was applied, and an antimonial and aperient saline ordered every six hours. On the following day, the lids were distended and tense, and there was great chemosis; the conjunctiva almost hiding the cornea; the pain also was great in the globe and forehead. Six leeches were ordered to the left temple, and warm fomentations. The above symptoms were still further aggravated on the following day, when several punctures were made in the upper lid, which afforded immediate relief. On the third day, the leeches were repeated, and three grains of calomel and half a grain of opium were ordered twice in the day. On the sixth day, the visible portion of the cornea was cloudy; and on the seventh, there was purulent discharge from the tense and projecting globe. On the evening of the same day, the muscles of the face on the right side appeared contracted, and the patient complained of stiffness about the jaws. On the ninth day, trismus was fully established, and the hemiplegic condition of the face had become more distinct. He had been blistered and cupped on the previous day. A puncture was made into the projecting globe, and gave exit to some foul pus. General tetanic symptoms subsequently supervened, and he died on the following morning, an ineffectual attempt having been made to affect him with the vapour of ether. On examining the body, the vessels within the cranium seemed to be congested; as were those of the mucous membrane lining the larynx and pharynx. The liver and kidneys were also gorged with blood. The globe of the affected eye was completely disorganized, its different component structures being scarcely at all distinguishable. The author considers the above case interesting from its extreme rarity, as he is unaware of any record existing of a similar lesion producing corresponding results. The apparent paralysis of the face he also regards as an interesting complication, and it was unexplained by the *post mortem* examination. The irritation and distress occasioned by the attempt to administer the vapour of ether, were such as to forbid perse-

verance in this endeavour to relieve the patient's frightful sufferings. In the tabular view which the author gives of ten other cases of tetanus admitted into St. George's Hospital since 1841, it appears that only two recovered. Seven of the fatal cases were traumatic, and the symptoms of the disease declared themselves within three weeks of the receipt of the injury, with one exception. In four cases, the brain was rather congested, and in one there was softening of the spinal cord. The author remarks, that no satisfactory conclusions can be drawn from the treatment of these cases, both opium and Indian hemp having proved uncertain and unsatisfactory remedies.—*Lond. Med. Gaz.*, June, 1847.

Mr. Dalrymple expressed the opinion, in the correctness of which we entirely coincide, that the tetanus, in this instance, seems referable to the violent secondary attack of inflammation of the globe, and the extension of irritation to the ciliary nerves, rather than to the primary injury of the cornea.

**39. Treatment of Dissection-wounds.**—Dr. HARGRAVES recommends the following as a simple, and in his experience, efficacious plan of treating dissection-wounds. It is applicable to the fingers and the thumb, the parts most frequently liable to be wounded:—Wash them well for a few minutes in cold water, then suck them; immediately after apply a ligature a little above the cardiac side of the wound with such tightness as will induce decided congestion, which will be indicated by the colour of the parts; some blood will also flow from the injured surface, and a certain degree of numbness will follow its application. The ligature is then to be firmly tied and knotted, and allowed to remain on for at least twelve hours; I have kept it on for double that period, and still pursued my professional engagements.

The physiology of such treatment is explained by the ligature causing a permanent stasis in the fluids of the part injured on its distal side, and producing a well-marked plethora there; the greater the amount of it, the greater will be the impediment to absorption. The constriction caused by the ligature, will also oppose a barrier to the return of the venous and lymphatic fluids into the system, consequently to their being circulated through it, so that the poison is prevented entering into the constitution and destroying it, and will then be eliminated locally from the part where it was first applied; thus suffering and pain will be obviated, and life, valuable to all, will be preserved.—*Dublin Med. Press.*

**40. New Mode of bandaging Wounds and Stumps.**—M. BAUDENS communicated to the French Academy of Sciences, June 6th, a method which he had lately devised, of bringing together the edges of wounds in order to unite, and which he is now daily employing with success at the hospital. For instance: in order to unite the two flaps of integument, after the operation for removing the foot at the ankle, as practised by him, a bandage is fixed circularly above the stump, and in it are inserted two strong pins, one in front, the other behind, leaving their heads and points free. Around the two ends of the pins thus left exposed, a long and thick cotton thread is looped; the threads from both sides are next brought down to the edge of the stump, and crossed over the lips of the wound, which are held together by the fingers of an assistant. The thread, being crossed over to the opposite side, is now passed under the ends of the pin of that side, from which, again, it may be made to recross: by this crossing of the threads of both sides over the wound, a support is given to it similar to that afforded by a bandage. The crossing of the threads may be repeated as often as is deemed necessary; and the course of the threads of opposite sides may be parallel, or across, so as to make a figure of eight. The ends of the ligatures applied to the arteries, being also made fast to the pins, are in no danger of being torn away in removing any applications from the stump, as will sometimes happen with the old plan.

The advantages this plan offers are—the gentle pressure exercised by the thread; the avoidance of impregnation by the discharged matter, which cannot long remain in contact with the end of the stump; the open spaces left between the threads allow of a ready discharge of fluid matters from the wound; and the constant pull upon the circular bandage above the stump tends to draw the flesh towards its extremity, and so to render it conical.

This mode of bringing about the union of parts is, according to M. Baudens,

applicable to all kinds of wounds, a suitable support being first contrived for the pins, on which the traction is exerted.

It may be remarked, however, that many surgeons object to a circular bandage being applied just above the stump, at least with any tightness, such as M. Baudens' method would require, on account of the impediment it offers to the circulation in the part, and the consequent tendency it has to produce an oedematous state, and even worse results. Nevertheless, even if the evils of constriction above a stump have not been magnified, the device of M. Baudens is very ingenious, and no doubt will prove very convenient and useful in procuring the adhesion of the opposite lips of wounds in many cases.—*Lancet*, June 26th, 1847.

**41. Fracture of the Upper Extremity of the Humerus traversing the Bicipital Groove, and detaching the greater Tubercls. By ROBERT SMITH, Esq.—**I was called upon to examine the body of Julia Darby, æt. 80, who had died of chronic pulmonary disease. Upon entering the room the appearances of the left shoulder-joint attracted my attention, and struck me as being different from those which attend the more common injuries of the joint. The shoulder had lost to a certain extent its natural rounded form; the acromion process, though unnaturally prominent, did not project as much as in any of the luxations of the head of the humerus. The breadth of the joint was doubled. Upon pressing beneath the acromion, I could plainly distinguish a portion of the head of the bone occupying the inner point of the glenoid cavity; it formed a tumour perceptible through the soft parts, while the remainder, and by far the larger portion of the head of the bone, lay beneath the level, and internal to the coracoid process; and between these two portions the finger sunk into a deep depression or sulcus, placed immediately below the coracoid process. The elbow could be brought into contact with the side, and there was no appreciable change in the length of the arm. Such were the external characters of the injury, and from these alone I was unable to pronounce positively as to its exact nature, but conjectured that it was some variety of luxation forwards. Upon removing the soft parts, the head of the bone presented itself, increased to nearly double its natural breadth; it lay beneath and internal to the coracoid process. The greater tubercle was completely broken off from the shaft of the humerus, and in situation corresponded to the inner part of the glenoid cavity; the fracture traversed the bicipital groove, which, in consequence of the displacement which the head of the bone had suffered, was situated exactly below the coracoid process; the glenoid cavity was changed both in form and size; it was smaller than natural, nearly flat, and broader above than below. A new shallow socket was formed for the head of the bone, upon the axillary margin of the scapula, and bony matter was deposited in the capsule, which was greatly enlarged; the cartilage had been nearly altogether removed from the head of the bone, which was covered by an ivory deposit.

What occurs in the cases under consideration is, in my opinion, simply this: a fracture, traversing the upper part of the bicipital groove, detaches the greater tubercle of the humerus, thus annulling the action upon the humerus of the supraspinatus, infra-spinatus, and teres minor; the folds of the axilla, the subscapularis, and the anterior portion of the deltoid, then, act almost unopposed, and draw the head of the bone forcibly inwards, against the inner part of the capsular ligament, and if, at the same time, the inner border of the glenoid cavity be broken (which I suspect is by no means a rare occurrence), the head of the bone passes still farther inwards, and beneath the coracoid process, amounting, at length, to an actual displacement, which is permitted by the increased size of the joint, just as a displacement of the head of the femur will often be the consequence of a fracture of the acetabulum.—*Dublin Quarterly Journal*, Nov. 1846.

**42. New and successful Operation for Pseudarthrosis.**—Dr. J. S. BESUNAN, in a letter in the *Medical Times*, Jan. 16th, relates the three following cases, in which a new method of curing false joint, caused by ununited fracture, was employed by Prof. DIEFFENBACH, with success. The two first were related to him by the operator, the third he witnessed himself.

CASE I. In the winter session of 1845, a woman, thirty-three years of age, presented herself at the Klinik; she had broken her thigh fifteen months previ-

ously. On examination, the fractured limb was found to be nearly three inches shorter than its fellow, and much withered or reduced in size, except at the fractured part, where there was a soft, circumscribed and considerable swelling. The limb was movable like the end of a flail, and with difficulty she dragged it after her as she moved on crutches; it was not only useless, but a positive inconvenience, causing her frequently to fall, and to stumble at every threshold; the poor woman earnestly desired its removal. There was some soft callus between the fractured bones in which they moved, as in a capsule, but no bony deposit. Dieffenbach caused the absorption of this grisly matter by rubbing the ends of the bones together, and thus setting up inflammatory action; and, this object effected, he attempted to produce bony union; not, indeed, by the usual and very uncertain routine of very close and accurate contact—removing the ends of the bones by excision, escharotics, or setons. His experience of gunshot wounds had taught him, that when foreign bodies, as bullets, are lodged in bones, a great quantity of healthy and hard callus is always poured over them; and the experiments of Duhamel and Floureens had established the fact, which it had remained for the genius of Dieffenbach to turn to account. So, having pierced the leg with a small scalpel down to the fractured bones, with a common gimlet, he drilled holes through each end of the bone, and about half an inch from each fractured extremity. Into each of these holes he introduced a small ivory peg, the same size as the gimlet, and strongly wedged them with a few strokes of a hammer. The limb was then extended, placed in splints, and carefully bandaged. In ten days it was apparent, from the less degree of mobility between the ends of the fractured bone, that healthy callus has been thrown out; and so the ivory pegs were removed, and the wounds allowed to heal. In three months from the date of the operation, the patient walked without crutches, and was dismissed cured.

CASE II. A strong hard-working man, aged thirty-one, had a year previously broken his right humerus, at about its middle part, while employed on a railroad. No union had taken place and the limb was useless. The same treatment as in the former case was had recourse to; the bones were bored with a gimlet, small ivory pegs introduced, and at the end of ten days removed. In the course of treatment, however, Dieffenbach was not satisfied with the rapidity of the progress towards bony union; he therefore introduced smaller pegs for a few days; and so successful did the case prove, that, twelve weeks from the first introduction of the pegs, the man was in a condition to resume his employment.

CASE III. I had the satisfaction of examining this patient, and witnessing the operation. He was a robust and apparently healthy man, of forty years of age, who, eighteen months previously, had met with an accident upon a railroad, by which he was much bruised and his left humerus fractured at the insertion of the deltoid. The limb was perfectly useless and much withered; the false joint was capable of being moved in all directions, giving little or no pain. The limb bore the marks of setons and issues; and indeed the man had undergone a regular routine practice, under the care of the surgeons whom he had consulted. The operation was rapidly performed, as in the preceding cases, and the limb bandaged and placed in a sort of cradle. At the end of a week there was much swelling of the limb, and pain in the fractured parts, which were not as movable as before; on the twelfth day it was still more difficult to move the parts, and on attempting to do so it appeared as if it were a very stiff joint; then the pegs were removed, and I did not again see the case. In my next letter, I doubt not, I shall be able to report most favourably of it, and ultimately to assure the medical public of its successful termination.

Let us compare these satisfactory results with the uncertain and unsuccessful practices which have hitherto, in similar cases, been resorted to. All are agreed as to the difficulty and danger and want of success in the operation recommended by Celsius, and practised in modern times, of sawing off the ends of the bones. Dr. Physick's proposal to introduce a seton between the fractured extremities, is recorded to have been often unsuccessful than otherwise. [This is erroneous. See the number of this Journal for Jan., 1842, p. 54, & seq.] Cutting down to the bones and rubbing them with caustic potass, has signally failed; and, indeed, it may be said, that hitherto amputation has been the only certain cure for pseudarthrosis. Dieffenbach's operation, on the other hand, is neither dangerous, nor

difficult, nor painful : and it may be performed with every prospect of success, by any one with sufficient anatomical knowledge to enable him to avoid the great vessels and nerves of the limbs.

43. *Vertical Dislocation of the Patella (de champ).*—[In our number for April, 1843, a case is recorded by Dr. GAZZAM, of Pittsburg, in which the patella was dislocated so as to rest on its edge. A similar case was recorded by Dr. John Watson, of New York, (see this Journal for Oct. 1839, p. 252,) and another has recently occurred under the observation of M. PAYEN.

This species of displacement was first described by Moscati. Monteggia related some cases of it; nevertheless Manne, and Léveillé after him, doubted whether it could occur, and Boyer denied its possibility. M. Malgaigne, in an elaborate memoir, (*Gaz. Méd. de Paris*, 1836, p. 673,) relates eight cases of this accident which he has collected from different authorities.

The following are the details of a case which has recently been related by M. Payen.]

"M. D., a strong robust man, about fifty years of age, was walking on the snow on the 15th of last December, when his right foot slipped backwards, thereby giving to the body a rapid rotatory movement in the same direction. Being on the point of falling, M. D. seized the railings that were within his reach, and thus immediately arrested, for the upper part of the body, the impulsion, which expended itself on the lower extremities. The violent torsion he thus experienced, occasioned him very acute pain in the right knee.

"It is quite certain that M. D. neither fell nor struck himself, as there was no mark upon the snow, and his clothes were not soiled. Persons came to his assistance, and supported him, when he made a few steps to enter his house.

"I was immediately sent for, and on my arrival, found the leg slightly flexed upon the thigh, the knee extremely painful, and strangely deformed. The patella was placed edgeways in front of the condyles of the femur, so that its external border, from having become anterior, raised the skin; its cutaneous surface was directed inwards and *rather backwards*, and its articular surface outwards and *rather forwards*, while its internal edge rested firmly on the anterior part of the extremity of the femur, a little external to the middle line; the muscles of the thigh were powerfully contracted, the slightest movement was impossible, and every effort caused very great pain.

"The patient having been placed in bed, with the limb resting on a mattress, I attempted to push the patella backwards by pressing the internal border from without inwards, with my thumbs, whilst with the other fingers I brought the external border from within outwards, but without success. I then flexed the thigh upon the pelvis, the leg being extended, as recommended by Valentine, and again tried, but with no better result. I then had recourse to the very rational method deduced by M. Malgaigne from his researches,\* and which M. Cozet had previously successfully employed in a case of *de champ* dislocation—viz., to forced flexion of the leg. But the first attempts occasioned such violent pain, and the contraction of the muscles of the thigh was so energetic, that I considered this mode as impracticable, and that I ought to abandon it.

"Convinced, from the reasons given by M. Malgaigne, that the difficulty of reduction in this case was owing to the angle of the patella being wedged in what he calls the *subcondyloid space*, and being unable to dislodge it by flexing the limb, I imagined that I might arrive at the same result by the opposite proceeding, that is, by causing the patella to ascend. To effect this, the limb being extended on the bed, I ordered the patient to raise his leg as much as possible, my fingers being at the same time so placed as to cause the patella to turn over. The patient obeyed, and made a sudden and violent effort; the patella yielded, and became somewhat raised, and then, with the combined assistance of my fingers, immediately reduced to its proper position. The knee immediately regained its shape, and was scarcely at all painful. The patient was ordered to keep in bed. Dur-

\* See his "Mémoire," p. 49, and his "Anat. Chirurg." art. Articulations du Genou.

† "Mém. de la Société Méd. d'Emulation," t. ix., p. 517, and the "Mémoire" already quoted, p. 68.

ing the first day the articulation was surrounded with compresses dipped in cold water. On the following day a swelling made its appearance on the inside of the knee, which gave the sensation of fluctuation. There was, however, no ecchymosis. On the seventh day, the knee was restored to its ordinary size, and but little pain was felt on moving the patella from side to side. I surrounded the knee and the adjoining parts of the thigh and leg with a dextrine bandage, and the next day the patient was able to walk about on crutches.

"On the twenty-sixth day I removed the bandage, and replaced it by a laced knee-cap. The patient was ordered to keep his room for a few days longer, and six weeks after the accident, M. D. went out on foot with merely the aid of a stick. He is now quite recovered."

M. Payen makes the following remarks on this case, which are worthy of being quoted.

1st. At the time M. Malgaigne published his essay, and from the facts which he had collected, we were justified in stating that the internal *de champ* luxations were more common than the external (5 to 3). The two new cases of MM. Watson and Gazzam, however, restored the equilibrium. Now, the one above related places the majority on the other side, that is, in favour of the external dislocations (6 to 5).

2d. Of the known cases of *de champ* luxation, those produced by mere muscular contraction are much the most rare, since only two of the ten cases I have just related—one external, and the other internal—are of this description. The one I have mentioned was external; and it seems rational to admit that the greatest number of dislocations of the patella, caused by muscular action alone, ought to take place in this direction, for it is to this side that the triceps tends to draw the bone, and we know that it is on this same side that what are called spontaneous luxations are always observed.

3d. The above case fully confirms M. Malgaigne's ideas as to the cause of the difficulty of the reduction, and it is evident that the proceeding we adopted could succeed only by disengaging the angle of the patella from the subcondyloid space. As regards the mode of reduction, our case is very analogous to that of Monteggi (M. Malgaigne's sixteenth observation), in which the patella became spontaneously reduced during the efforts made by the patient in walking. In both cases the bone was dislodged from its wedged position by the same mechanism; we may, therefore, reasonably establish the precept, viz., to assist the reduction by making the patient stand up, or even by making him walk.

4th. As regards the facility of the reduction, our case holds an intermediate position between the extreme cases; and we may mention that, of the eight recorded by M. Malgaigne, the difficulty was so great in four that, in one, division of the muscles and of the ligamentum patellæ was resorted to without success; in two others, the elevation was obliged to be employed; and that in a fourth, the reduction was impossible. We may also add that in the case of Dr. Gazzam, the bone was not reduced till after the ligamentum patellæ had been divided, yet this division did not apparently facilitate the reduction.

5th: It has been said that the greater or less facility in the reduction depends on the cause of the displacement, and that the luxations of the patella produced by muscular contraction are more easy to reduce than others. May not this depend on the action of the muscles alone not being, generally speaking, sufficient, unless there is some anatomical disposition to favour the displacement; and which, consequently, facilitates the inverse route which the bone has to pass through in order to become reduced? Still I may remark, that in one case where M. Cuynat was obliged to employ the elevator, the dislocation was occasioned by muscular contraction. However, notwithstanding that, M. Malgaigne's opinion, as to the partial and spasmodic contractions of the triceps femoris being a cause of the luxation of the patella, is contested.\* I, nevertheless, entirely coincide with it; indeed, it appears to me to be corroborated by the case we have related, for we cannot comprehend how there can be complete harmony of contraction in the inordinate and discordant movements above described. These isolated contractions of the muscular fibres appear to me incontestable; it is stated in all our treat-

\* A. Berard, "Dict. de Méd.", vol. xxvii., p. 646.

ises on anatomy, that when the arm is raised, the anterior portion of the deltoid contributes to carry it forwards, and the posterior portion backwards; the same, in fact, with numerous other muscles. We, therefore, see no difficulty in acknowledging the preponderating contraction of one portion of the triceps femoris, as a cause of certain dislocations of the patella; and M. Malgaigne has very truly affirmed that the simultaneous action of all the muscles of a joint tends to consolidate, and not to modify, its relations.

6th. It has been stated that there may be some difficulty in ascertaining whether the *de champ* luxation is external or internal; in the above case, no doubt could possibly exist; and the patella, evidently placed outside the middle line, pointed out very clearly the direction of the displacement. I am not aware that it is the same in every case; still the examination of the surfaces of the patella ought to be an indication, as it proved to be in our patient.

7th. As to the information said to be furnished by the extensor tendon and the ligamentum patellæ—the internal border of which, being more tense, indicating an internal luxation, and *vice versa*—we have endeavoured in vain to appreciate its value; the ligamentum patellæ, when forcibly stretched, did not present any distinct or appreciable border.

8th. Lastly, in the case I have given, I have mentioned that the surfaces of the patella had become placed not merely laterally, but that the posterior was external, and at the same time rather anterior; and the anterior internal, and a little posterior. This disposition was sufficiently marked for me not to hesitate to admit the possibility of the *upside-down* luxation; and I am convinced that if M. D. had fallen on the knee after the displacement of the patella, this dislocation, in a more or less complete form, would have been produced.—*Revue Medico-Chirurgicale de Paris*, May 1847.

44. *Partial Dislocation of the Humerus and of the Femur.*—In 1824 the surgeon-in-chief of one of the Paris hospitals presented to the Academy a pathological specimen, taken from a man who died eight months after suffering from a dislocation of the humerus, which had not been reduced. It exhibited a false joint, formed on the one hand by the glenoid cavity of the scapula, and a small portion of the surface of the ribs, and on the other by the head of the humerus, which was grooved to receive the anterior border of the glenoid cavity, the two surfaces being thus locked together, so as to constitute a sort of hinge-joint. During life the only motions which could be performed were in a direction from before backwards, and that to a limited extent. In a case of spontaneous luxation of the femur, the same surgeon found the softened head of the bone resting on the anterior border of the cotyloid cavity, and there firmly locked, as in the preceding case. These, then, are two well authenticated instances of *partial dislocation* of the two orbicular articulations, the improbable occurrence of which led all authors to deny the possibility of their existence.—*Dupuytren on Injuries and Diseases of the Bones*. Translated by Le Gros Clarke.

45. *Treatment of Chronic Cystitis by injections of a solution of Nitrate of Silver.*—Dr. ROBERT L. MACDONNEL, in an interesting paper in the *British American Journal of Medical and Physical Science*, (Sept. 1847,) extols, in strong terms, the efficacy of injections of nitrate of silver, in chronic inflammation of the bladder,—a disease which has proved very refractory to other remedies, and which entails on those who labour under it, the most exquisite suffering. In proof of the value of the remedy, he relates four cases, one of which is the following:

“A gentleman consulted me last February, under the following circumstances. He had suffered for some months from inflammation of the bladder, marked by frequent desire to pass water, accompanied by heat and scalding, violent straining, pain in the region of the bladder, above the pubis and in the perineum, and a constant feeling of heat and weight in the lower portion of the abdomen. These symptoms gradually increased in severity. The urine became at first bloody, and afterwards purulent, and the desire to void it became so urgent, that it had to be yielded to at least every fifteen minutes; the discharge of the fluid being followed by pain and scalding at the neck of the bladder, and along the course of the urethra. His general health became impaired; and his sleep being so frequently

disturbed, a haggard and anxious expression of countenance, and extreme irritability of the system, were soon established.

"When he first consulted me, fully one-half of the fluid passed from the bladder was pure pus; and after repose, a deposit of blood-globules was found to intervene between this and the supernatant urine—the latter being highly alkaline, fetid, and albuminous. Examined microscopically, it exhibited some scales of nucleated epithelium, a large deposit of triple phosphate in prismatic crystals, pus, and blood-globules. There was no pain in the loins or along the ureters. He had a stricture of long standing, about one inch from the orifice of the urethra. In addition to the above characters, the urine was frequently mixed with tenacious masses of lymph, varying in length from half an inch to an inch,\* and entangling a quantity of earthy matter; they frequently obstructed the passage of the urine through the stricture, and required to be broken up and squeezed through by the pressure of the patient's fingers.

"Having dilated the stricture, so as to allow a large-sized catheter (No. 11, Weiss) to pass, I determined to treat the disease by injections of nitrate of silver; and accordingly, on the 17th of February, I injected into the bladder, a lotion composed of eight grains of lunar caustic, two drachms of tincture of hyoscyamus, and four ounces of distilled water.

"The injection caused hardly any inconvenience, except that of inducing a strong desire to empty the bladder, which was prevented by compressing the penis, until the fluid had been in the bladder for about one minute, when it was allowed to escape. The next day, the patient stated that he was somewhat better, but the quantity of pus and blood was not, however, much diminished, and the flakes of lymph were more numerous and larger than before. Although he continued improving, yet, as the amendment was not as rapid as I anticipated, injection of the viscous was again resorted to on the 5th of March. On this occasion, the quantity of caustic was increased to sixteen grains in the four ounces of distilled water, and the hyoscyamus was omitted. A decided improvement immediately followed; the frequency of making water was greatly diminished; instead of requiring to be voided every fifteen minutes, the bladder could retain its contents for more than two hours at a time, and the quantity of pus had greatly decreased. An injection, of the same strength, was again employed on the 28th of March, and with happy results. The urine could now be retained for three or four hours; was passed without pain or scalding; was clear and transparent, and, to the naked eye, free from pus; but, when examined microscopically, a deposit of pus-globules and some epithelial scales were perceptible. On the 18th of April, I repeated the injection, and since then he has been completely free from any symptoms of his troublesome disease; he has resumed his former mode of life and pursuits, and has been subject to various changes of temperature whilst travelling, without experiencing the least return of his former symptoms."

The method of injecting the bladder which Dr. MacDonnell has found most efficient is the following:—

"The patient being placed either in the erect position or on a sofa, a gum elastic catheter, about the size of No. 9 or 10 (Weiss), is introduced, and water at the temperature of 98° Fahr., is injected through this into the bladder, by means of a caoutchouc bag, or, what I prefer, a syringe, with a "three-way valve," by which the fluid can be drawn back from the cavity if necessary. After the bladder has been completely cleansed of any fetid urine and mucus which may be contained in it, the solution of the caustic, being heated to the same degree, is to be introduced in a similar manner, and allowed to remain there for about one minute, care being taken, by compressing the urethra, to prevent its being forcibly ejected by the violent straining that is certain to be induced. The quantity of water or solution should never exceed four ounces, for though the bladder in its healthy state is capable of containing nearly a pint and a half of urine, without being

\* C'est encore dans les cas de suppuration, qu'on trouve des productions pseudo-membraneuses dont parlent les auteurs. C'est l'expulsion de ces fausses membranes par l'uréthre qui a fait répéter à tant de médecins que la tanique muqueuse de la vessie pouvait être entièrement détachée et expulsée par portions avec les urines.  
—FERREUS, Dict. de Méd., Art. *Cystite*.

over distended, yet as the quantity it is capable of retaining in severe chronic inflammation, seldom exceeds a few tablespoonfuls, the bladder accommodates itself to its diminished contents, and gradually becomes smaller, and consequently, a large injection would act injuriously in two ways—by over distending the organ, or by passing up into the ureters. In fact, we find it unnecessary to use a larger quantity of the solution than I have mentioned, for it requires some address to introduce even that amount without resorting to force. The patient is then ordered a warm bath, and should the urine become bloody or mixed with shoddy concretions, he should use frequent fomentations and anodynes. But these symptoms seldom last for more than a few hours, and our patient should always be informed that such consequences are likely to be the immediate effects of the operation.

"My patients have not suffered from retention of urine, which it appears frequently follows the use of the solid nitrate in the practice of Lallemand, nor have they had any inconvenience which was not readily allayed by an opiate.

"The advantages which I consider the solution of nitrate of silver possesses over that substance in a solid form are, first, that we can employ it of various strengths, from one to four grains, or even stronger if necessary. Secondly, we are certain that the application comes in contact with the entire diseased surface. Thirdly, we are also satisfied that it does not act more violently on one part than on another. Fourthly, it is more readily employed by an inexperienced operator; and, above all, it cannot possibly be attended with any risk, from the apprehension of which it is not easy to divest the mind, when using the *porte-caustique* of Lallemand, and together with the above advantages, it has this also to recommend it, that it will be found at least equally successful."

46. *Successful Extirpation of an Ovarian Tumour.*—Dr. WOYEIKOWSKI, of Quinney, was called to a woman who was some hours in labour—the pains were trifling, the waters had escaped, and a fleshy tumour protruded shortly after from the vagina. The patient, aged 40, had had three children within the previous three years—but while she experienced the same symptoms of pregnancy in the present instance as in the former ones, she was surprised at going three months beyond her proper time. On examination Dr. W. found the protruding tumour to be the uterus, about three times its natural size,—the os sufficiently open to admit the index finger; he was unable to return the parts; the abdomen was greatly distended with fluid, and was so tender to the touch as to prevent any examination of the contained organs. Paracentesis was performed with a trocar, and thirty-five litres of a yellowish, transparent, inodorous fluid drawn off. The hand was now enabled to detect a tumour in the abdomen the size of a man's head, round, irregular in its surface, perfectly indolent, and floating in the upper pelvis; the patient felt and moved it with her hands, and implored that it might be taken away. The uterus could now be returned without any difficulty, and the other contents of the abdomen appeared perfectly sound; the patient was kept in bed on rigidly low diet until next day, when a consultation was requested with those surgeons whom she had applied to formerly, when she found the ninth month had passed without any signs of labour coming on. The diagnosis was found very embarrassing, but gastrotomy was decided on. The patient was placed on a reclining couch; Dr. W. stood on the right side of her and an assistant on the left; an incision was made through the skin with a convex bistoury along the linea alba from three fingers' breadth above the umbilicus down to the pubis; the cellular tissue and aponeurosis were next divided in the same direction, taking care not to touch the peritoneum, which was easily avoided, there being no subcutaneous fat; a small opening was now made into the peritoneum at the highest part of the previous incision, through which the index finger of the left hand was passed and against its point the end of a button bistoury rested, with which the peritoneum was laid open the whole length of the wound in the parietes, and immediately full thirty litres more of a similar fluid to what had been discharged by the trocar previously, was received in a vessel in readiness, besides what fell on the floor. The great omentum and small intestines immediately protruded and lay on the patient's thighs. The assistant (M. Matusewicz) returned them and retained them *in situ* with a napkin spread with salve. A round tuberculated swelling was now seen, firm to the touch, floating in the superior pelvis, and attached to the right side of the uterus near its fundus by a

pedicle half an inch in diameter and three inches long. An exploring puncture was made into this tumour with the bistoury, and the sensation given to the hand was as if the knife was traversing old lard; this convinced the operator that it was a scirrhouss ovary. One of the assistants raised it in his hands while a ligature was put round the pedicle close to the uterus; the end of the ligature was retained out of the wound, and the tumour was detached by a stroke of the knife. The lips of the wound were immediately brought together and retained by eight points of suture (quill) tied on pieces of diachylon plaster rolled up. The patient was then put to bed lying on her back with her legs and thighs flexed. Cloths wrung out of cold water were applied to the abdomen, and ordered to be renewed every five minutes; low diet, and a few spoonfuls of lemonade for a drink. The operation lasted eight minutes. The tumour was carefully examined; it weighed six pounds and a half, (fr.) it was smooth and irregular on its surface, and the rudiments of the Fallopian tube and its extremity were easily distinguished on it. Its structure was lardaceous, yellow, and very resisting, and some small collections of pus were found in its substance. On the 2d of May (twenty-four hours after the operation) she remained without pain or fever; the lips of the wound were a little tumefied. 3d. General state continued satisfactory; lips of the wound a little more tumid; the patient had enjoyed a quiet sleep, and begged something more nutritious to eat, which it was thought proper to refuse. 4th. A kindly suppuration was established. The ligature soon came away; the wound healed, and on the 25th day after the operation she walked home to a neighbouring town, with a swathe round her, such as is worn after confinement. About four months after this, this woman became pregnant, and at the usual period was delivered of a healthy boy; she lay in again of another boy equally thriving in December last. It would seem that the assertion made by the father of medicine, that male children were developed at the right side and females at the left, might, *en passant*, be proved to be incorrect from this case, for it was the right ovary that was extirpated in this instance.—*Dublin Med. Press*, June 30th, from *Journ. de Méd et de Chirurg.*

47. *Vesico-vaginal Fistula*.—The *Comptes Rendus*, for the 14th of June, contains an interesting report, by MM. ROUX, VELPEAU and LALLEMAND, on a memoir of Dr. JOBERT, on vesico-vaginal fistula, and on a new mode of operating, devised by himself.

The report commences by observing that the present memoir is, in some measure, a continuation of that read by the author on the treatment of some forms of urinary fistula in men, too extensive to be cured by the ordinary means. The conditions of these male urinary fistulae are of the same character as the vesico-vaginal in the female; and the same principles of cure M. Jobert applies in both. Before proceeding with the description of the plan of M. Jobert, it is as well to glance at the different processes which have been employed to repair the loss of substance.

The most ancient method is that of transplantation; as where a piece of skin was removed from the forehead or arm to repair a portion of the nose. Now, in this manœuvre, the portion of integument, being quite removed from the original source of its vascular supply, is very liable to mortify, and its purpose thus fails. Dr. Jobert, in his first attempts to heal vesico-vaginal fistulas, had recourse to this plan; but he has now entirely given it up, although he employed it successfully in two cases.

An improvement in autoplastic operations was contrived by using a portion of skin from the immediate neighbourhood of the chasm it was required to fill, but leaving it attached by a pedicle, so that it still continued to receive blood from some of its original channels. This process has been called autoplasty by dissection.

When the skin is very elastic and loose, and when it has beneath it an abundance of areolar tissue, a portion of it may be drawn to one side, without so much stretching being necessary as to endanger union. This is what Dr. Jobert has done when he has made use of a part of the scrotum to repair great losses of the substance of the urethra. This variety of autoplasty (*autoplastie par glissement*) is still more advantageous than the preceding, since the skin here has not at all to be dissected off to fill up the breach, but only to be relieved from tension, so as to

contract adhesion. And it is readily seen how the resulting integrity of the sub-cutaneous areolar tissue favors the vitality of the portion of skin.

It is true that all the tissues have not, like the scrotum, numerous folds easy to unfold in any direction; but those which have beneath an abundant cellular tissue will still admit of being considerably displaced, when, at some distance from the margins of the loss of substance to be repaired, a sufficiently long incision is made in the direction of its great diameter. Then the parts being brought together by suture, and stretching tells especially on this incision previously made. This last method is more strictly one of sliding (*glissement*) than the preceding. It is now necessary to examine what are the difficulties to be overcome in the healing of vesico-vaginal fistula.

The first obstacle presenting itself is the constant contact of the urine with the inner orifice. In urethral fistula, the urine is only discharged at intervals, and is under the control of the will; but in a fistula opening into the bladder itself, the urine will continually dribble through it. And from the slight thickness of the septum between the bladder and vagina, the fistula cannot be long, oblique, or sinuous, but the urine immediately passes into the vagina: and it also follows, that when we wish to unite the margins, they cannot be brought into contact but to a little extent. Lastly, the partition between the bladder and vagina being between two cavities, is loose, and has no firm support on each side, and the borders brought into apposition may easily be drawn to one or the other side; and, moreover, the surfaces adapted for union may be in actual contact only by the mucous membrane of the bladder, or by that of the vagina, and we know that mucous membranes cannot contract adhesions. These things being granted, we shall comprehend what takes place in the different kinds of vesico-vaginal fistula, according to their extent, their date, &c.

At the termination of a difficult delivery, for example, if the fissure be very narrow, and the inflammation of the surrounding parts be sufficiently intense, as by their swelling to bring the margins into contact, a spontaneous cure may happen. But this happy termination is exceedingly rare, because it is difficult to maintain the margins sufficiently long, and intimately in contact, for a distended bladder may at once destroy the work of cicatrization.

When inflammation subsides before cicatrization is complete, the urine will escape through the accidental opening left. If, then, a more free escape for the urine be provided by a catheter than that presented by the fistular orifice, the obstacle to complete union is removed; but that it may be so, the orifice must be almost capillary. After a time, cauterization may be used to a small orifice with callous edges, to cause inflammation, and consequent union. But every time cauterization is employed, a portion of substance is destroyed, more in proportion as the cautery is more potent; also, the chance of producing union decreases every time the cautery is employed afresh.

When vesico-vaginal fistulae are not so narrow that inflammation may bring their borders into contact, some artificial proceeding must be adopted to do so, and to maintain the apposition during the time necessary for cicatrization; these cases are by far the more numerous. Provided the opening be not too extensive, it is possible to maintain its borders in apposition, without too great a stretching of the neighbouring tissues, and union may take place before the sutures tear through the flesh, since five or six days suffice for the organization of a cicatrice between surfaces fitted for it.

But the vesico-vaginal septum may suffer from still greater losses of substance, and the opening deserves no longer the name of a fistula, as it may be so wide as to allow the bladder to be inverted into the vagina: here, then, the ordinary means of union are inefficient. When even the suture may be able to draw the opposite margins into contact, so much dragging is caused, that soon the overstretched tissue tears, and the sutures lose their hold to a greater or less extent, and thus the opening is re-formed, the urine can still escape, and the contact is not so close as to permit the occurrence of adhesion. Hence, such severe cases have been regarded as beyond the resources of art, for no method of which surgeons were cognizant sufficed for their cure; they were obliged to have recourse to mechanical expedients to render the patient's misery less.

M. Jobert would not give such cases up in despair, but applied himself to the

invention of a method of operating, the application of which it seems difficult to limit, since by it he has repaired nearly the entire vesico-vaginal septum, which had been destroyed by gangrene, in the course of a laborious confinement.

After having successfully employed *autoplastie par glissement* to close up wide urethral fistulae situated in front of the scrotum, M. Jobert thought he might apply the same plan to considerable losses of substance of the vesico-vaginal partition, and he used it in cases where the second mode of autoplastic operating—that where the flap is dissected up, but left attached by a pedicle—had completely failed. The following are some of the anatomical grounds on which this new idea was founded:—

The vesico-vaginal septum consists of two distinct walls, applied to each other, but not confounded, the free or mucous surfaces of which enter into the construction of organs of different functions. The wall of the bladder is separated from that of the vagina by an abundant and elastic cellular tissue, allowing of the distension of one of the cavities independent of the other, and of the displacement of one without the other. It is, then, possible to cut the wall of the vagina without interfering with the mucous membrane of the bladder, or with its muscular layer outside. Now this wall of the bladder is alone necessary to the repair of the viscus; we can then, in cases of considerable destruction of the double septum, do away with the tension of the parietes of the vagina after the union of the edges of the fistula, by cutting through this wall only, outside the points of suture. The dragging produced by too great tension is thus rendered naught, the rapid tearing of the flesh by the threads is consequently prevented, as also the separation of the margins. Thus, for example, the vesico-vaginal septum being destroyed, from the neck of the bladder nearly to its fundus, the borders of this enormous fissure may be brought together, and placed in contact, from before backwards, by employing sutures; then, if a transverse incision be made in the wall of the vagina, between the threads and the neck of the womb, without penetrating to the muscular parietes of the bladder, the uterus may regain its position by the divarication of the lips of the incision, and the cellular coat of the bladder alone is exposed, at the upper end of the vagina. In this way the remnants of the vesico-vaginal septum, preserving their entire thickness, and being in contact, may be maintained for a long time in apposition, and without suffering from dragging, although the margins have not been previously shaved. On the other hand, the posterior wall of the bladder being drawn downwards and forwards, becomes the inferior wall, and serves to close the opening into the bladder. If the bladder thus completed is rendered smaller, it is made up of the same layers—viz., mucous membrane and muscular fibres. The evacuation of urine may be rendered more frequent, but still it is subject to the will.

The preceding is not merely hypothetical, but the result of observations; and M. Jobert had a patient, whose vesico-vaginal septum was destroyed, as above supposed, by gangrene, which also had extended to the urethra; and yet the new neck of the bladder, though formed of only remnants, allowed the urine to be retained for three hours, under all the ordinary movements of the body, and was under the control of the will.

If the fistula be elongated, and occupy the median line, a double incision may be made from behind forwards, between the line of the sutures and the lateral walls of the vagina, in order to avoid the evils of any transverse draggings. If the fistula be on the right or on the left side, the incision should be made in the corresponding vaginal wall, which alone would be stretched. Then the line of suture along with the wound, would be drawn towards the median line. In a word, incisions ought to be made in the vaginal walls at all the tense parts which appear affected by dragging. Such is the plan of Dr. Jobert, which has the further advantage of being without danger. The author has found it to succeed in six out of eight cases.

As to the operation, it is less difficult than appears at first sight. Some time back, Lisfranc showed that the neck of the womb might, without inconvenience, and with ease, be drawn down to the opening of the vulva, by seizing it on each side. Now, the uterus, in descending, draws with it the vesico-vaginal partition; it is then sufficient for an assistant to retain it in its depressed position, whilst the posterior wall of the vagina is pressed down towards the rectum, in order to give

the operator the opportunity of bringing together the borders of the fistula almost as easily as he could external parts. The threads of the suture are then passed through by an instrument. Before letting go the neck of the womb, to allow it to re-ascend, any tension or dragging must be done away with by incision. The ends of the sutures are cut off on a level with the vulva. A piece of amadon is introduced into the vagina, to absorb the blood, and a catheter placed in the bladder, to give free vent to the urine.

The reporters conclude by remarking that this plan allows us to hope for the cure of vesico-vaginal fistula, which would be pronounced incurable by any other means. The size of the opening is no longer to be regarded as an insurmountable obstacle; nor is its deep situation, its longitudinal or oblique direction, or its irregular form.

The preceding abstract of the report on M. Jobert's memoir is rather long, but we thought its subject of so high importance, as to give it so far in full. Any improvement of our modes of relieving those formidable and most miserable ruptures and destructions of the substance of the septum between the bladder and vagina, and of the perineum, to which women are exposed in difficult childbirth, must be received as a great boon. We cannot here help noticing the likeness in principle between the plan of M. Jobert for the cure of vaginal fistula, and that practised by Mr. Fergusson for cleft palate.—*Lancet*, Aug. 7th, 1847.

48. *New Method of Treatment for Prolapsus Ani.* By T. G. HAKE, M. D., (*London Medical Gazette*, Feb. 1847.)—This method consists in returning the bowel or hemorrhoidal tumours with great care after the daily motion; in assisting its return by means of soap-lather; in applying a coil of moist sponge firmly upon the anus, and, while retaining it there with one hand, to bring the nates together by means of a broad strip of adhesive plaster, as in approximating the edges of a wound.

This method Dr. Hake has tried in several cases, and it has never failed of success. It was first suggested by a patient whose experience is embodied in the annexed letter.

"The account I promised you is as follows:—More than seven years ago, after very severe discipline, which I suppose was necessary to treat an illness that lasted many weeks, I began to be troubled with a prolapsus ani to a distressing extent. I had suffered from symptoms of it occasionally—slight symptoms, I mean, hardly worth mentioning—at times during several years before, but I took no notice of them, not knowing, indeed, what they indicated; and from time to time they came and disappeared. But in 1839, after the illness I have alluded to, there was a prolapsus every day after breakfast, and I mentioned it to a surgeon, who gave me a wash for it, but it did no good, and he did not warn me sufficiently against what it might come to. The consequence was that it went on, and did come to so much as to make my life very miserable. It generally cost me much time and trouble to restore the part to its place, and when it had been restored, there was no certainty how long it would stay there; in addition to this, there were irritation and bleeding, and running of a yellowish sort of lymph, as often as the evil returned, so that all standing, walking, and riding, were sure to lead to great suffering, and the prolapsus at times was very large. I could not find that I derived any considerable, and certainly no lasting benefit, from any treatment I was under; and though, by Mr. Copland's advice, I made use of the belts and bandages that are advised in such cases, they brought me, upon the whole, nearly as much annoyance as they relieved. This made me determine to go to work for myself, and, with more thought, and a longer time, perhaps, than you would suppose, I came at last to the following very simple contrivance, for which I can never be thankful enough when I say it has answered perfectly from the beginning, and has given me such entire comfort, with the power to do what I like without pain or inconvenience, as I never expected to have again. My contrivance is this. Take a piece of sponge four or five inches long, an inch and a half wide, and half an inch thick, the more elastic a bit you can find the better; roll this, in a damp but not wet state, pretty tightly, so that the roll, if relaxed, would be ready to spring back into its full length, and it will then make a roll of some little substance round, but still soft, and its length, when thus rolled, will of course be an inch and a half. Apply it then lengthwise to the anus, so that it may be pressed, about the

centre of it, quite home and firmly to that part. Taking care that it may remain so, stretch a length of adhesive plaster, about 14 inches long, and 3*3* wide, more or less, straight across the nates, rather low down, and contrive so that while the plaster adheres on one side, you press the other side closer to its opposite before you fix the length finally where it is to remain. Then sit down, at first gently upon it, and it will become very firm and fast as long as the plaster is good. I need not say that these two pressures constantly going on do the work capitally, and without any inconvenience worth speaking of—I mean the two pressures of the roll of sponge always striving to unwrap itself, and the cross-band of adhesive plaster always keeping it from doing so by holding the nates sufficiently close together to hinder it. The working is really perfect when a little use and management have got a person into the way of it. But to facilitate matters I will set down a few observations, at the risk of being tedious and more particular than I need be.

"I never put this on until that time of day when I am going to be standing about, or to take exercise, whether walking, riding, or driving; but it should be put on then for all of these. In the evening, I take off the plaster, but leave the sponge in its place, where it has got by that time so firmly fixed by gradual spreading and swelling, that there is no danger that anything short of a great exertion will loosen it; and it is, of course, more comfortable to do without the plaster when it is not wanted. The sponge should be washed in cold water every time it is taken off, and in cold weather the plaster should just cross the fire before it is put on; in moderately warm weather it will adhere of itself, especially if it is sat upon for half a minute. The same plaster is better the second day than even the first, and will do very well the third day; this where economy is an object."

"Wash the parts where the plaster goes every morning, or oftener, with cold water, or water and vinegar; wash them well, and the skin will never suffer."

"If the plaster leaves something sticky behind it, when it is taken off, rub it with a very little spirit of wine, and the towel will remove it."

"If there be an irritation about the anus, or gut that comes down, wash it with vinegar and water, and the relief will be wonderful, and that part of the evil soon cured. This wash cannot be too much praised for this purpose, for piles, and for the like. I leave it for you to say whether something might not be dropped upon the sponge, or the sponge dipped in something which would promote a complete cure. What I have said is perfectly cleanly, secures exercise and comfort, and very gradually, I believe, tends to set things right again."

49. *Cold Water in cases of severe Burns.* By Dr. KÜSTEN.—A case of very extensive burning, treated most successfully by the prolonged application of cold water, has been recorded by Dr. Küsten, the particulars of which seem to indicate the great advantage which may probably be derived from this mode of treatment in most cases of severe burns. Dr. Küsten was first led to set a high value on the use of cold water in such cases, by observing the good effects which resulted from it, in the case of his own child, nine months old, which was severely scalded about the neck, chest, and abdomen, by the upsetting of a tea-kettle containing boiling water. The application of cold water was commenced immediately after the child's dress was removed: very abundant vesicative power had already taken place in the form of numerous large and small blisters. For six hours, without intermission, the application of cold wet cloths was continued: the cloths being replaced by others as quickly as they became warm. At the end of this time, the smaller vesicles had quite disappeared, and the places occupied by the larger ones were indicated by more or less intensely reddened spots. The child meanwhile had fallen asleep, and it slept soundly the whole night, (the accident having occurred about six o'clock in the evening). On the following morning the only trace of the burn consisted of a dry shrivelled appearance of the cuticle on one small spot; and this peeled off in a day or two.

The case, however, in which the beneficial effects of this mode of treatment were especially illustrated, occurred in a brandy distiller, who, in consequence of the bursting of the still, was extensively scalded over the body by the boiling and blazing spirit. The man's head, at the time of the accident, was fortunately covered by a thick cloth cap, and escaped injury; but the upper part of the body, being defended only by a shirt, suffered severely. When seen by Dr. Küsten,

about an hour after the accident, the patient was almost unconscious: he lay moaning, and constantly ejaculating "Fire!" After washing off, by means of a watering-pot, the layers of scraped potatoes which had been spread over the burned surface, it was found that over the whole body, down to the lower part of the thighs, there was scarcely a spot which was not more or less injured. The slightest degree of injury was manifested by vesication; but over the neck, chest, arms, and abdomen, the skin in places was quite destroyed. Dr. Küsten immediately covered the entire burnt surface with linen; and for an hour this was kept constantly cold and wet, by pouring cold water over it from a watering-pot. After pausing for five or six minutes, the application of cold water was renewed, and continued for another hour, at the end of which time the man had recovered from his state of partial unconsciousness. He was then left, with directions that the application of the cold water should be continued as before. When seen about six hours afterwards, the patient was in a promising condition: his face was slightly flushed; eyes open; pulse 100. He complains of a sense of general burning, which was relieved by drinking, and by the repeated application of cold water to the burnt surface. This application was continued until the patient complained of being cold. On examining the injured part the following day, the places which were previously occupied by the vesications, were indicated only by intense redness; the other part had much the same appearance as before: portions of the destroyed skin came off on removing the dressing. The injured parts were then dressed with cloths dipped in vinegar, and kept constantly wet by sprinkling cold water on them. The patient had some sleep during the night, and on the following day the reddened portions of skin had resumed almost their natural colour: commencing granulations were observed along the margins, and within the spaces of the surfaces, where the skin had been destroyed. The pulse was 90, the thirst less intense, and the tongue less dry than on the preceding day. For nine more days the same treatment was continued, and with the happiest results, for at the end of this time the wounds were almost healed.

In the treatment of such severe wounds by this mode, the dressing must, of course, be changed at least once in the twenty-four hours.

Dr. Küsten mentions one or two other instances, in which the healing of burns, of various degrees of severity, was effected most rapidly and satisfactorily by this continued application of cold water.—*Lond. Med. Gaz.*, July, from *Caspar's Wochenschrift*, May 1, 1847.

50. *Treatment of Burns with Treacle.*—Mr. BULLEY has introduced to the notice of the profession, molasses as a dressing for burns. The plan he recommends is to steep cloths in a mixture of one part treacle to two of water, and apply them over the burnt surface. He attributes the beneficial results of this mode of treatment to the prevention of those metastases of inflammation to internal organs which were so liable to take place after severe burns. It should be applied warm, (at a temperature of 98°.) He attributes its remedial power to fermentation which takes place in the treacle. He had found that anything producing cold renders the liability to metastasis greater.—*Provincial Med. and Surg. Journal*, Aug. 25, 1847.

51. *Treatment of Erysipelas by Linear Blistering.*—M. PIORRY affirms that he has discovered a means of limiting the inflammatory action of erysipelas. This means consists in applying narrow blisters around the entire circumference of the inflamed skin, at a distance of an inch or two from its border. Unfortunately for M. Piorry's fame, this same discovery was made long ago, by the late Professor Physick, of Philadelphia; but, unhappily for humanity, it does not always succeed.

52. *Hypertrophy of the Septum Nasi successfully treated.* By M. BRICLET, of Dijon.—This affection is so rare that it has not been mentioned by authors, and both its diagnosis and treatment have to be determined.

"A boy, 10 years old, was brought to me," the author remarks, "to be relieved of a tumour seated in the nasal fossæ, which were obliterated by it. The tumour was as hard as bone, and seated immediately at the external orifice of these cavi-

ties; it was manifestly developed in the cartilaginous septum, forming a plug like a hard ball, of the size of a small nut. Regarding it as an hypertrophy of the cartilage, I believed that it might be removed. I proceeded in the following manner: I separated the inferior part of the septum, even unto its junction to the upper lip; a cut with scissors was sufficient for this. I then cut away with a tenotome all the hypertrophied part; with one point of suture reunion was immediately effected, and it was impossible to perceive where the operation had been performed to relieve the child of this singular obstruction."

We have but once met with an analogous case. A child of 10 years old was believed to have a polypus. The right nostril was half obstructed by a reddish, hard, rounded projection, which manifestly projected from the cartilaginous septum, and yet it was not a simple obliquity; since, in the left nostril, the septum maintained its normal direction. As the obstruction was not complete, and the mucous membrane appeared a little swelled, we contented ourselves with prescribing slight cauterization, with nitrate of silver, and have not seen the child since.

The "Annales de la Société de Médecine d'Anvers," for January, 1847, contains a case, if not identical, at least analogous to that of M. Brulet. It is described as follows.

*Obliquity and considerably increased length of the cartilages of the septum nasi; resection of a part of the cartilage; disappearance of the deformity.* By M. HEYLEN.—J. C., aged 21 years, had from youth a very disagreeable deformity, consisting in a deviation to the right of the inferior part of the cartilage of the septum nasi, and a too great length of this cartilage, which formed a tumour in the right nostril, projecting from a line beneath the sub-septum, without any change in the relation of this to the other parts of the nose. Besides the deformity, pain was produced by the motions of the mouth. For a long time we hoped to rectify the cartilage by dilatation; but its length prevented success. We then proposed to resect the projecting portion of the septum. An incision made on the right side of the cartilage allowed the mucous membrane covering the projecting part to be dissected from both sides, and the projection to be separated with scissors. The resection of the cartilage was easily effected, but the tenacity of the mucous membrane opposed the reunion of the edges of the wound, and we had to introduce the end of a small sound, protected with agglutinative bandages, into the right nostril, to keep the septum in place during the cicatrization.

Three days after the operation no inflammation had occurred; the septum was in a greatly improved position, and its obliquity was no longer perceptible externally. In nine days cicatrization was complete, and the deformity had quite disappeared.

The fear of making a cicatrix under the septum of the nose, and thereby increasing the obliquity, induced us to choose this mode of operating. Still we think there would be no risk in making an incision of the septum laterally, in dissecting the cartilage from both sides, separating the parts, and then uniting the wound, to obtain cicatrization by the first intention.—*Ranking's Abstract*, vol. v., from *Rev. Méd. Chirurg. de Paris*, Feb. 1847.

53. *Sublingual Tumour.—Salivary Calculus.—Dilatation of Wharton's Duct.*—As cases of salivary calculi, especially in Wharton's duct, are very rare, we record the following case briefly, as contained in the *Gazette des Hôpitaux*.—It occurred in the practice of M. ROBERT, at the Hospital Beaujon, in a man who had suffered nearly eight years from an enlargement of the sub-maxillary gland and a sub-lingual tumour. The tumour, small at first, had gone on gradually increasing up to the time of his admission into the hospital, when it had attained such a magnitude as considerably to impede the movements of the tongue, and to interfere with the speech and deglutition. M. Robert made an incision over Wharton's duct, when there issued a large quantity of viscous and transparent saliva, together with a calculus concretion, of the volume and form of a pistachio nut. The duct was enormously dilated, having the calibre of a large goose-quill. After the incision had been made, the tumour shrunk and disappeared, showing that it was chiefly dependent on the arrest of the flow of saliva, and not solely on the presence of the calculus. The orifice of the canal was not completely closed; and

hence it was that the patient had been enabled to postpone an operation so long a time.

The reporter of this case in the *Gazette*, states that a case, given by Sabatier, is the first of the kind on record, and that, since his time, three cases have been collected and published by Dr. Dourlens, of Lille, in 1837. The first of these three cases was mistaken by a surgeon for an abscess, depending on alveolar caries, and a canine and two molar teeth were extracted. But the tumour went on increasing, and M. Dourlens detected a salivary calculus in Wharton's duct, which he extracted after some trouble, on account of adhesions which had been formed. It was of the size of a garden bean, and weighed ten grains. The second case was that of a woman, aged twenty-seven, who had suffered seven years from acute pain in the left side of the lower jaw, radiating thence to the neck and ear. For some months the speech and swallowing had been affected, and the saliva pressed out was thick and purulent. As in the former case, a hard movable tumour, and of large size, was detected. The calculus was cut down upon, and removed, its many adhesions having been destroyed. It was of the size and form of an almond, and weighed fifteen grains. The third case was similar to that reported above. The calculus was for some time but a matter of inconvenience, but by-and-by set up active inflammation, accompanied with a purulent discharge in the mouth, and succeeded by a chronic inflammatory state, lasting for two years, and giving rise to the formation of pus. The calculus could easily be felt beneath the buccal mucous membrane, and appeared of the size of a haricot bean. The Whartonian duct was greatly dilated. As the concretion was only a source of inconvenience, M. Dujardin did not risk an operation.—*Lancet*, June 12th, 1847.

51. *Tracheotomy in Croup*.—M. GUERSANT communicated to the *Société de Médecine Pratique*, (Jan. 7, 1847,) an account of an operation for tracheotomy, performed on a child 14 years of age, who had been labouring under croup for four or five days, and who was commencing to become asphyxiated. The patient recovered. M. G. stated that this was the fifth successful case out of forty-one, in which he had performed the operation for true croup.—*Gazette des Hôpitaux*, 23 Feb. 1847.

55. *Ascites cured by the Iodine Injection into the Peritoneal Cavity*.—M. LERICHE of Lyons, reports, in the *Journ. de Méd. de Lyons*, the following case:

A girl, aged 17, of weak constitution, has regularly menstruated since the age of 14, and became affected in the month of January, 1846, with ascites, after a slight pulmonary affection. Diuretics and drastic medicines had been unsuccessfully resorted to. The circumference of the abdomen measured one mètre seven centimètres (three feet eight inches). On the 11th of March paracentesis was performed, and eleven quarts of fluid withdrawn. The following solution of iodine was injected immediately afterwards into the peritoneum: R.—Tinct. iod.  $\frac{5}{2}$ ; potassæ hydriod.  $\frac{5}{2}$ ; aquæ fontanæ  $\frac{5}{2}$ viii. Four ounces only of this solution returned after injection; the remainder was abandoned in the abdomen. The following night the patient complained of some slight pains and borborygmi. The urine was increased in abundance, and on the third day considerable flatulence was observed. Up to March 21, the nights were sleepless, the urine clear and abundant, and great weakness was present; but the strength and appetite returned from that day forward, the abdomen continuing to decrease in size, and a complete cure was finally obtained on March 30.—*Med. Times*, May 29th, 1847.

[May not this have been a case of encysted, or of extra-peritoneal dropsy?]

56. *Purulent Infection*.—M. SEDILLOT believes that authors have too generally regarded this affection as constantly fatal in consequence of their only taking into consideration extreme cases. He establishes a distinction between *purulent affection* and *metastatic abscesses*. As long as the disease is confined to the former condition, it may be cured; if there are abscesses only of small size, or few in number, all hope is not extinct; death only being inevitable when these are very numerous or large, or open into the pleura, the articulations, &c. The effects vary much, also, not only according to the quantity of pus mingled with the blood,

but also according to its qualities—the pus from a phlegmon producing much less deleterious effect than a sanguous pus. Wounds of the perineum, in which there is a mixture of pus and urine, produce, even when the suppuration is not very abundant, fatal effects in a very brief space of time. It may be replied to the statement that the less advanced cases of purulent affection recover, that such were not examples of the disease at all; but M. Sedillot believes the pathological changes induced in man and animals from this cause are the same, and numerous experiments upon these last have proved to him—1. That a small quantity of pus injected into the veins only produces slight effects. 2. If the injection be repeated for several successive days, thirst, shivering, &c., are produced; but the animal continues to live if they are then discontinued—so that we must kill it in order to observe the pathological alterations at this period, such as patches in the lungs, emphysema, &c. 3. If a new portion of pus be daily injected, death takes place, always producing the same changes.

The lungs are the organs in which pus is found to be most frequently deposited in this affection; then follow the pleura, the joints, the liver, and the muscles. Although veins are constantly found leading from the source of pus, in a great number of cases no trace of *phlebitis* is visible. After amputations, in deep-seated phlegmons, in chronic suppuration, caries, &c., it is always by means of the divided or eroded veins that a direct communication between the purulent centre and the circulation is established, and the mixture of pus with blood which this gives rise to is one of the best ascertained phenomena of the disease. The constant obliteration of the veins by coagula, even in the cases in which they are inflamed, is contrary to the statement of most authors, an exceptional occurrence. The coagulum, when it exists, does not adhere to the walls of the vein, but floats in the pus, having an elongated, fusiform, shape. If it is interrupted from place to place, the blood remains fluid in the intervals, having lost its red colour, and become converted into a sanies by admixture with pus.

Recognizing different stages of this affection, and its curability in some of these, M. Sedillot enumerates the following indications of treatment. 1. Combating the inflammatory symptoms, if intense, by bleeding, especially local. 2. Modifying the surface secreting the pus, in the case of a wound. This is to be done by stimulant lotions or baths, or injections of aromatic wine. In this way the vitality of the tissues becomes modified, and the pus changed in qualities, or its secretion arrested. 3. Furnishing ample exit for pus by prompt incisions if necessary. 4. The frequent renewal of dressings. 5. The use of the actual cautery. This is often very efficacious. 6. If purulent infection seems threatened after attempting union by the first intention, the commencing cicatrix is to be broken, and the edges of the solution of continuity irritated. 7. A revulsive action of the secretory organs is to be maintained, especially by the use of purgatives. 8. Cold fluids should be drank in abundance, to maintain the venous system in a state of repletion, and diminish its absorbing powers as much as possible. 9. Counter-irritants should be applied in the vicinity of any organs suffering from derangement of function. 10. Tonics are not indicated until the febrile action has declined, and true prostration set in. 11. In the case of symptoms of infection occurring in a carious limb, amputation offers the best resource if its performance be not too long delayed.—*Med. Chirurg. Rev.*, July 1847, from *Recueil de Mém. de Méd., de Chirurg., et de Pharm. Militaires*, vol. lxii.

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#### OPHTHALMOLOGY.

57. *Treatment of Scrofulous Inflammation of the Eye.*—Prof. JACOB, of Dublin, is publishing in the *Dublin Medical Press*, a series of extremely interesting papers on diseases of the eye. In one of these we find the following judicious remarks on the treatment of scrofulous ophthalmia.

"In providing for the treatment of an attack of inflammation of the eyeball in a truly scrofulous subject, the practitioner has to consider carefully, the probable effect of the remedies he usually employs in ordinary cases, when applied to this form of disease. When alluding to the treatment of simple, uncomplicated, or